AMENDED IN ASSEMBLY APRIL 9, 2014

AMENDED IN SENATE FEBRUARY 14, 2013

SENATE BILL No. 20

Introduced by Senator Hernandez

December 3, 2012

An act to amend ~~Section 1341.45 of the Health and Safety Code, relating to health.~~ *Section 100503 of the Government Code, to amend Sections 1348.95 and 1399.849 of the Health and Safety Code, and to amend Sections 10127.19 and 10965.3 of the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

SB 20, as amended, Hernandez. ~~Health care: workforce training.~~ *Health care coverage.*

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual. PPACA also requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified.

Existing law establishes the California Health Benefit Exchange within state government, specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified

individuals and small employers. Existing law requires the board to undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange and to undertake outreach and enrollment activities that seek to assist with enrolling in the Exchange in the least burdensome manner. Existing law also requires the board of the Exchange to annually prepare a written report on the implementation and performance of the Exchange functions during the preceding fiscal year, as specified, and requires that this report be submitted to the Legislature and the Governor and be made available to the public on the Internet Web site of the Exchange.

This bill would require the annual report to also include an assessment of how the Exchange is performing compared to its operational and service principles for its Internet Web site and customer service center, a summary of the Exchange's outreach strategy for the enrollment of consumers with limited English language proficiency and insufficient access to the Internet, and the total number of covered lives under qualified health plans purchased through the Exchange, as well as specified additional data regarding those lives.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer, on and after October 1, 2013, to offer, market, and sell all of the plan's insurer's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan or insurer provides or arranges for the provision of health care services, as specified, but requires plans and insurers to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. Existing law requires a plan or insurer to provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, and annual enrollment periods for plan years on or after January 1, 2015, from October 15 to December 7, inclusive, of the preceding calendar year.

This bill would authorize the Exchange to modify the initial open enrollment period and the first annual enrollment period to the extent permitted by PPACA, and would require individual health benefit plans to comply with those modifications whether offered inside or outside the Exchange.

Existing law requires a health care service plan or health insurer to annually report, by March 31, the number of enrollees by product type as of December 31 of the prior year that receive coverage under a plan contract or health insurance policy that covers individuals, small groups, large groups, or administrative services only business lines. Existing law requires that plans and insurers include the enrollment data in specific products types as determined by the department.

This bill would instead specify those product types and would also require plans and insurers to report their enrollment in nongrandfathered coverage by coverage tier, if applicable, and by whether the coverage was purchased through the Exchange or outside the Exchange. The bill would also require a plan offering individual plan contracts or a health insurer offering individual health insurance policies to, by May 1, 2014, or within 30 days after the end of the initial open enrollment period described above, report to the department the plan's or insurer's enrollment as of March 31, 2014, or the end of the initial open enrollment period, whichever date is later, by product type, coverage tier, age and gender, and whether coverage was purchased inside or outside the Exchange, as specified. The bill would require the departments to report this data to the fiscal and appropriate policy committees of the Legislature by June 1, 2014, or within 60 days of the end of the initial open enrollment period, whichever date is later.

Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and imposes certain requirements on health care service plans. Existing law imposes, for certain violations of these provisions, various fines and administrative penalties, which are deposited in the Managed Care Administrative Fines and Penalties Fund. Existing law requires the first $1,000,000 in the fund to be transferred each year to the Medically Underserved Account for Physicians in the Health Professions Education Fund for purposes of the Steven M. Thompson Physician Corps Loan~~

~~Repayment Program. Existing law requires all remaining funds to be transferred each year to the Major Risk Medical Insurance Fund for purposes of the Major Risk Medical Insurance Program.~~

~~This bill, beginning on the date that the Major Risk Medical Insurance Program becomes inoperative, would instead require all the funds in the Managed Care Administrative Fines and Penalties Fund to be transferred each year to the Medically Underserved Account for Physicians in the Health Professions Education Fund for purposes of the Steven M. Thompson Physician Corps Loan Repayment Program. The bill would require the Director of Finance to notify the Joint Legislative Budget Committee in that regard.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. Section 100503 of the Government Code, as amended by Section 4 of Chapter 5 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

100503. In addition to meeting the minimum requirements of Section 1311 of the federal act, the board shall do all of the following:

(a) Determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange and coordinate that process with the state and local government entities administering other health care coverage programs, including the State Department of Health Care Services, the Managed Risk Medical Insurance Board, and California counties, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage.

(b) Develop processes to coordinate with the county entities that administer eligibility for the Medi-Cal program and the entity that determines eligibility for the Healthy Families Program, including, but not limited to, processes for case transfer, referral, and enrollment in the Exchange of individuals applying for assistance to those entities, if allowed or required by federal law.

(c) Determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of

qualified individuals and qualified small employers. The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.

(d) Provide, in each region of the state, a choice of qualified health plans at each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act.

(e) Require, as a condition of participation in the Exchange, carriers to fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act. The board may require carriers to offer additional products within each of those five levels of coverage. This subdivision shall not apply to a carrier that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504.

(f) (1) Except as otherwise provided in this section and Section 100504.5, require, as a condition of participation in the Exchange, carriers that sell any products outside the Exchange to do both of the following:

(A) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(B) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(2) For purposes of this subdivision, “product” does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Managed Risk Medical Insurance Board and carriers for enrolled Healthy Families beneficiaries or contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the State Department of Health Care Services and carriers for enrolled Medi-Cal

beneficiaries. “Product” also does not include a bridge plan product offered pursuant to Section 100504.5.

(3) Except as required by Section 1301(a)(1)(C)(ii) of the federal act, a carrier offering a bridge plan product in the Exchange may limit the products it offers in the Exchange solely to a bridge plan product contract.

(g) Determine when an enrollee’s coverage commences and the extent and scope of coverage.

(h) Provide for the processing of applications and the enrollment and disenrollment of enrollees.

(i) Determine and approve cost-sharing provisions for qualified health plans.

(j) Establish uniform billing and payment policies for qualified health plans offered in the Exchange to ensure consistent enrollment and disenrollment activities for individuals enrolled in the Exchange.

(k) Undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange. The board shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency.

(*l*) Select and set performance standards and compensation for navigators selected under subdivision (*l*) of Section 100502.

(m) Employ necessary staff.

(1) The board shall hire a chief fiscal officer, a chief operations officer, a director for the SHOP Exchange, a director of Health Plan Contracting, a chief technology and information officer, a general counsel, and other key executive positions, as determined by the board, who shall be exempt from civil service.

(2) (A) The board shall set the salaries for the exempt positions described in paragraph (1) and subdivision (i) of Section 100500 in amounts that are reasonably necessary to attract and retain individuals of superior qualifications. The salaries shall be published by the board in the board’s annual budget. The board’s annual budget shall be posted on the Internet Web site of the Exchange. To determine the compensation for these positions, the

board shall cause to be conducted, through the use of independent outside advisors, salary surveys of both of the following:

(i) Other state and federal health insurance exchanges that are most comparable to the Exchange.

(ii) Other relevant labor pools.

(B) The salaries established by the board under subparagraph (A) shall not exceed the highest comparable salary for a position of that type, as determined by the surveys conducted pursuant to subparagraph (A).

(C) The Department of Human Resources shall review the methodology used in the surveys conducted pursuant to subparagraph (A).

(3) The positions described in paragraph (1) and subdivision (i) of Section 100500 shall not be subject to otherwise applicable provisions of the Government Code or the Public Contract Code and, for those purposes, the Exchange shall not be considered a state agency or public entity.

(n) Assess a charge on the qualified health plans offered by carriers that is reasonable and necessary to support the development, operations, and prudent cash management of the Exchange. This charge shall not affect the requirement under Section 1301 of the federal act that carriers charge the same premium rate for each qualified health plan whether offered inside or outside the Exchange.

(o) Authorize expenditures, as necessary, from the California Health Trust Fund to pay program expenses to administer the Exchange.

(p) Keep an accurate accounting of all activities, receipts, and expenditures, and annually submit to the United States Secretary of Health and Human Services a report concerning that accounting. Commencing January 1, 2016, the board shall conduct an annual audit.

(q) (1) ~~Annually~~ *(A) Notwithstanding Section 10231.5, annually* prepare a written report on the implementation and performance of the Exchange functions during the preceding fiscal year, including, at a minimum, ~~the~~ *all of the following:*

(i) The manner in which funds were expended and the progress toward, and the achievement of, the requirements of this title. ~~The report shall also include data~~

(ii) Data provided by health care service plans and health insurers offering bridge plan products regarding the extent of health care provider and health facility overlap in their Medi-Cal networks as compared to the health care provider and health facility networks contracting with the plan or insurer in their bridge plan contracts. ~~This~~

(iii) An assessment of how the Exchange is performing compared to its operational and service principles for its Internet Web site and customer service center. If the Exchange determines that it is not meeting those operational and service principles, the report shall also include a plan describing how the Exchange intends to meet those principles.

(iv) A summary of the Exchange's outreach strategy for the enrollment of consumers with limited English language proficiency.

(v) A summary of the Exchange's outreach strategy for the enrollment of consumers lacking sufficient access to the Internet.

(vi) The total number of lives covered under qualified health plans purchased through the Exchange as of the end of the immediately preceding fiscal year.

(vii) The percentage of lives reported under clause (vi) receiving a premium tax credit under Section 36B of the federal Internal Revenue Code of 1986.

(viii) The percentage of lives reported under clause (vi) enrolled in each of the levels of coverage identified in Sections 1367.008 and 1367.009 of the Health and Safety Code and Sections 10112.295 and 10112.297 of the Insurance Code.

(ix) The age, race, and ethnicity of the lives reported under clause (vi).

(B) The report *required by this paragraph* shall be transmitted to the Legislature and the Governor and shall be made available to the public on the Internet Web site of the Exchange. A report made to the Legislature pursuant to this ~~subdivision~~ *paragraph* shall be submitted pursuant to Section 9795.

(2) The Exchange shall prepare, or contract for the preparation of, an evaluation of the bridge plan program using the first three years of experience with the program. The evaluation shall be provided to the health policy and fiscal committees of the Legislature in the fourth year following federal approval of the bridge plan option. The evaluation shall include, but not be limited to, all of the following:

(A) The number of individuals eligible to participate in the bridge plan program each year by category of eligibility.

(B) The number of eligible individuals who elect a bridge plan option each year by category of eligibility.

(C) The average length of time, by region and statewide, that individuals remain in the bridge plan option each year by category of eligibility.

(D) The regions of the state with a bridge plan option, and the carriers in each region that offer a bridge plan, by year.

(E) The premium difference each year, by region, between the bridge plan and the first and second lowest cost plan for individuals in the Exchange who are not eligible for the bridge plan.

(F) The effect of the bridge plan on the premium subsidy amount for bridge plan eligible individuals each year by each region.

(G) Based on a survey of individuals enrolled in the bridge plan:

(i) Whether individuals enrolling in the bridge plan product are able to keep their existing health care providers.

(ii) Whether individuals would want to retain their bridge plan product, buy a different Exchange product, or decline to purchase health insurance if there was no bridge plan product available. The Exchange may include questions designed to elicit the information in this subparagraph as part of an existing survey of individuals receiving coverage in the Exchange.

(3) In addition to the evaluation required by paragraph (2), the Exchange shall post the items in subparagraphs (A) to (F), inclusive, on its Internet Web site each year.

(4) In addition to the report described in paragraph (1), the board shall be responsive to requests for additional information from the Legislature, including providing testimony and commenting on proposed state legislation or policy issues. The Legislature finds and declares that activities including, but not limited to, responding to legislative or executive inquiries, tracking and commenting on legislation and regulatory activities, and preparing reports on the implementation of this title and the performance of the Exchange, are necessary state requirements and are distinct from the promotion of legislative or regulatory modifications referred to in subdivision (d) of Section 100520.

(r) Maintain enrollment and expenditures to ensure that expenditures do not exceed the amount of revenue in the fund, and

if sufficient revenue is not available to pay estimated expenditures, institute appropriate measures to ensure fiscal solvency.

(s) Exercise all powers reasonably necessary to carry out and comply with the duties, responsibilities, and requirements of this act and the federal act.

(t) Consult with stakeholders relevant to carrying out the activities under this title, including, but not limited to, all of the following:

(1) Health care consumers who are enrolled in health plans.

(2) Individuals and entities with experience in facilitating enrollment in health plans.

(3) Representatives of small businesses and self-employed individuals.

(4) The State Medi-Cal Director.

(5) Advocates for enrolling hard-to-reach populations.

(u) Facilitate the purchase of qualified health plans in the Exchange by qualified individuals and qualified small employers no later than January 1, 2014.

(v) Report, or contract with an independent entity to report, to the Legislature by December 1, 2018, on whether to adopt the option in Section 1312(c)(3) of the federal act to merge the individual and small employer markets. In its report, the board shall provide information, based on at least two years of data from the Exchange, on the potential impact on rates paid by individuals and by small employers in a merged individual and small employer market, as compared to the rates paid by individuals and small employers if a separate individual and small employer market is maintained. A report made pursuant to this subdivision shall be submitted pursuant to Section 9795.

(w) With respect to the SHOP Program, collect premiums and administer all other necessary and related tasks, including, but not limited to, enrollment and plan payment, in order to make the offering of employee plan choice as simple as possible for qualified small employers.

(x) Require carriers participating in the Exchange to immediately notify the Exchange, under the terms and conditions established by the board when an individual is or will be enrolled in or disenrolled from any qualified health plan offered by the carrier.

(y) Ensure that the Exchange provides oral interpretation services in any language for individuals seeking coverage through

the Exchange and makes available a toll-free telephone number for the hearing and speech impaired. The board shall ensure that written information made available by the Exchange is presented in a plainly worded, easily understandable format and made available in prevalent languages.

(z) This section shall become inoperative on the October 1 that is five years after the date that federal approval of the bridge plan option occurs, and, as of the second January 1 thereafter, is repealed, unless a later enacted statute that is enacted before that date deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 100503 of the Government Code, as added by Section 5 of Chapter 5 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

100503. In addition to meeting the minimum requirements of Section 1311 of the federal act, the board shall do all of the following:

(a) Determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange and coordinate that process with the state and local government entities administering other health care coverage programs, including the State Department of Health Care Services, the Managed Risk Medical Insurance Board, and California counties, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage.

(b) Develop processes to coordinate with the county entities that administer eligibility for the Medi-Cal program and the entity that determines eligibility for the Healthy Families Program, including, but not limited to, processes for case transfer, referral, and enrollment in the Exchange of individuals applying for assistance to those entities, if allowed or required by federal law.

(c) Determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board

shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.

(d) Provide, in each region of the state, a choice of qualified health plans at each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act.

(e) Require, as a condition of participation in the Exchange, carriers to fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act. The board may require carriers to offer additional products within each of those five levels of coverage. This subdivision shall not apply to a carrier that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504.

(f) (1) Require, as a condition of participation in the Exchange, carriers that sell any products outside the Exchange to do both of the following:

(A) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(B) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Managed Risk Medical Insurance Board and carriers for enrolled Healthy Families beneficiaries or contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the State Department of Health Care Services and carriers for enrolled Medi-Cal beneficiaries.

(g) Determine when an enrollee's coverage commences and the extent and scope of coverage.

(h) Provide for the processing of applications and the enrollment and disenrollment of enrollees.

(i) Determine and approve cost-sharing provisions for qualified health plans.

(j) Establish uniform billing and payment policies for qualified health plans offered in the Exchange to ensure consistent enrollment and disenrollment activities for individuals enrolled in the Exchange.

(k) Undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange. The board shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency.

(*l*) Select and set performance standards and compensation for navigators selected under subdivision (*l*) of Section 100502.

(m) Employ necessary staff.

(1) The board shall hire a chief fiscal officer, a chief operations officer, a director for the SHOP Exchange, a director of Health Plan Contracting, a chief technology and information officer, a general counsel, and other key executive positions, as determined by the board, who shall be exempt from civil service.

(2) (A) The board shall set the salaries for the exempt positions described in paragraph (1) and subdivision (i) of Section 100500 in amounts that are reasonably necessary to attract and retain individuals of superior qualifications. The salaries shall be published by the board in the board's annual budget. The board's annual budget shall be posted on the Internet Web site of the Exchange. To determine the compensation for these positions, the board shall cause to be conducted, through the use of independent outside advisors, salary surveys of both of the following:

(i) Other state and federal health insurance exchanges that are most comparable to the Exchange.

(ii) Other relevant labor pools.

(B) The salaries established by the board under subparagraph (A) shall not exceed the highest comparable salary for a position of that type, as determined by the surveys conducted pursuant to subparagraph (A).

(C) The Department of Human Resources shall review the methodology used in the surveys conducted pursuant to subparagraph (A).

(3) The positions described in paragraph (1) and subdivision (i) of Section 100500 shall not be subject to otherwise applicable provisions of the Government Code or the Public Contract Code and, for those purposes, the Exchange shall not be considered a state agency or public entity.

(n) Assess a charge on the qualified health plans offered by carriers that is reasonable and necessary to support the development, operations, and prudent cash management of the Exchange. This charge shall not affect the requirement under Section 1301 of the federal act that carriers charge the same premium rate for each qualified health plan whether offered inside or outside the Exchange.

(o) Authorize expenditures, as necessary, from the California Health Trust Fund to pay program expenses to administer the Exchange.

(p) Keep an accurate accounting of all activities, receipts, and expenditures, and annually submit to the United States Secretary of Health and Human Services a report concerning that accounting. Commencing January 1, 2016, the board shall conduct an annual audit.

(q) (1) ~~Annually~~ *(A) Notwithstanding Section 10231.5, annually* prepare a written report on the implementation and performance of the Exchange functions during the preceding fiscal year, including, at a minimum, ~~the~~ *all of the following:*

(i) The manner in which funds were expended and the progress toward, and the achievement of, the requirements of this title. ~~This~~

(ii) An assessment of how the Exchange is performing compared to its operational and service principles for its Internet Web site and customer service center. If the Exchange determines that it is not meeting those operational and service principles, the report shall also include a plan describing how the Exchange intends to meet those principles.

(iii) A summary of the Exchange's outreach strategy for the enrollment of consumers with limited English language proficiency.

(iv) A summary of the Exchange's outreach strategy for the enrollment of consumers lacking sufficient access to the Internet.

(v) The total number of lives covered under qualified health plans purchased through the Exchange as of the end of the immediately preceding fiscal year.

(vi) The percentage of lives reported under clause (v) receiving a premium tax credit under Section 36B of the federal Internal Revenue Code of 1986.

(vii) The percentage of lives reported under clause (v) enrolled in each of the levels of coverage identified in Sections 1367.008 and 1367.009 of the Health and Safety Code and Sections 10112.295 and 10112.297 of the Insurance Code.

(viii) The age, race, and ethnicity of the lives reported under clause (v).

(B) The report *required by this paragraph* shall be transmitted to the Legislature and the Governor and shall be made available to the public on the Internet Web site of the Exchange. A report made to the Legislature pursuant to this ~~subdivision~~ *paragraph* shall be submitted pursuant to Section 9795.

(2) In addition to the report described in paragraph (1), the board shall be responsive to requests for additional information from the Legislature, including providing testimony and commenting on proposed state legislation or policy issues. The Legislature finds and declares that activities including, but not limited to, responding to legislative or executive inquiries, tracking and commenting on legislation and regulatory activities, and preparing reports on the implementation of this title and the performance of the Exchange, are necessary state requirements and are distinct from the promotion of legislative or regulatory modifications referred to in subdivision (d) of Section 100520.

(r) Maintain enrollment and expenditures to ensure that expenditures do not exceed the amount of revenue in the fund, and if sufficient revenue is not available to pay estimated expenditures, institute appropriate measures to ensure fiscal solvency.

(s) Exercise all powers reasonably necessary to carry out and comply with the duties, responsibilities, and requirements of this act and the federal act.

(t) Consult with stakeholders relevant to carrying out the activities under this title, including, but not limited to, all of the following:

(1) Health care consumers who are enrolled in health plans.

(2) Individuals and entities with experience in facilitating enrollment in health plans.

(3) Representatives of small businesses and self-employed individuals.

(4) The State Medi-Cal Director.

(5) Advocates for enrolling hard-to-reach populations.

(u) Facilitate the purchase of qualified health plans in the Exchange by qualified individuals and qualified small employers no later than January 1, 2014.

(v) Report, or contract with an independent entity to report, to the Legislature by December 1, 2018, on whether to adopt the option in Section 1312(c)(3) of the federal act to merge the individual and small employer markets. In its report, the board shall provide information, based on at least two years of data from the Exchange, on the potential impact on rates paid by individuals and by small employers in a merged individual and small employer market, as compared to the rates paid by individuals and small employers if a separate individual and small employer market is maintained. A report made pursuant to this subdivision shall be submitted pursuant to Section 9795.

(w) With respect to the SHOP Program, collect premiums and administer all other necessary and related tasks, including, but not limited to, enrollment and plan payment, in order to make the offering of employee plan choice as simple as possible for qualified small employers.

(x) Require carriers participating in the Exchange to immediately notify the Exchange, under the terms and conditions established by the board when an individual is or will be enrolled in or disenrolled from any qualified health plan offered by the carrier.

(y) Ensure that the Exchange provides oral interpretation services in any language for individuals seeking coverage through the Exchange and makes available a toll-free telephone number for the hearing and speech impaired. The board shall ensure that written information made available by the Exchange is presented in a plainly worded, easily understandable format and made available in prevalent languages.

(z) This section shall become operative only if Section 4 of the act that added this section becomes inoperative pursuant to subdivision (z) of that Section 4.

SEC. 3. Section 1348.95 of the Health and Safety Code is amended to read:

1348.95. *(a) (1)* Commencing March 1, 2013, and at least annually thereafter, every health care service plan~~, not including a health care service plan offering specialized health care service~~

~~plan contracts~~, shall ~~provide~~ *report* to the department, in a form and manner determined by the department in consultation with the Department of Insurance, the ~~number of enrollees, by product type, as of December 31 of the prior year, that receive health care coverage under a health care service plan contract that covers~~ *plan's enrollment under its plan contracts, excluding specialized health care service plan contracts, that cover* individuals, small groups, large groups, or administrative services only business lines *as of December 31 of the immediately preceding year*. ~~Health care service plans shall include the enrollment data in specific product types as determined by the department, including, but not limited to, HMO, point-of-service, PPO, grandfathered, and Medi-Cal managed care. The~~ *This report shall, at a minimum, include the following information:*

(A) The plan's enrollment in nongrandfathered coverage by product type (HMO, point-of-service, PPO, EPO, Medi-Cal managed care, or other), coverage tier (catastrophic, bronze-HSA, bronze, silver-HSA, silver, gold, or platinum), if applicable, and whether the coverage was purchased through the Exchange or outside the Exchange.

(B) The plan's enrollment in grandfathered coverage by product type (HMO, point-of-service, PPO, EPO, Medi-Cal managed care, or other).

(2) The department shall publicly report the data provided by each health care service plan pursuant to this ~~section~~ *subdivision*, including, but not limited to, posting the data on the department's Internet Web site. ~~The~~

(b) (1) In addition to the report required under subdivision (a), by May 1, 2014, or within 30 days after the end of the initial open enrollment period described in subdivision (c) of Section 1399.849, whichever date is later, a health care service plan offering individual health care service plan contracts shall report to the department, in a form and manner determined by the department in consultation with the Department of Insurance, the plan's enrollment under its individual health care service plan contracts, excluding specialized health care service plan contracts, as of March 31, 2014, or the date on which the initial open enrollment period described in subdivision (c) of Section 1399.849 ends, whichever date is later. The report shall, at a minimum, include the following information:

(A) The plan's enrollment in nongrandfathered coverage by product type (HMO, point-of-service, PPO, EPO, Medi-Cal managed care, or other), coverage tier (catastrophic, bronze-HSA, bronze, silver-HSA, silver, gold, or platinum), age and gender, and whether the coverage was purchased through the Exchange or outside the Exchange.

(B) The plan's enrollment in grandfathered coverage by product type (HMO, point-of-service, PPO, EPO, Medi-Cal managed care, or other) and by age and gender.

(2) (A) By June 1, 2014, or within 60 days after the end of the initial open enrollment period described in subdivision (c) of Section 1399.849, whichever date is later, the department shall report to the fiscal and appropriate policy committees of the Legislature, and post publicly on the department's Internet Web site, the enrollment data submitted by each health care service plan pursuant to this subdivision.

(B) The requirement for submitting a report to the fiscal and appropriate policy committees of the Legislature under this paragraph is inoperative four years after the date on which the report required under this paragraph is due, pursuant to Section 10231.5 of the Government Code.

(c) The department shall consult with the Department of Insurance to ensure that the data *collected and* reported *pursuant to this section* is comparable and consistent~~, does not duplicate existing reporting requirements,~~ and utilizes existing reporting formats *to the extent feasible*.

(d) For purposes of this section, the following definitions shall apply:

(1) "Exchange" means the California Health Benefit Exchange established under Section 100500 of the Government Code.

(2) "Grandfathered coverage" means coverage that constitutes a grandfathered health plan under Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

(3) "Nongrandfathered coverage" means coverage that does not constitute grandfathered coverage.

SEC. 4. Section 1399.849 of the Health and Safety Code is amended to read:

1399.849. (a) (1) On and after October 1, 2013, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan provides or arranges for the provision of health care services. A plan shall limit enrollment in individual health benefit plans to open enrollment periods, *annual enrollment periods,* and special enrollment periods as provided in subdivisions (c) and (d).

(2) A plan shall allow the subscriber of an individual health benefit plan to add a dependent to the subscriber's plan at the option of the subscriber, consistent with the open enrollment, annual enrollment, and special enrollment period requirements in this section.

(b) An individual health benefit plan issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.

(c) (1) A plan shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, and annual enrollment periods for ~~plan~~ *policy* years *beginning* on or after January 1, 2015, from October 15 to December 7, inclusive, of the preceding calendar year*, subject to paragraph (3)*.

(2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar year individual health plan contracts, a plan shall *also* provide a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

(3) To the extent permitted by PPACA, the Exchange may, by regulation, modify the initial open enrollment period and the annual enrollment period for the policy year beginning on January 1, 2015. A health benefit plan offered in the individual market shall comply with those modifications regardless of whether the plan is offered inside or outside the Exchange. A regulation adopted pursuant to this paragraph shall be considered by the Office of Administrative Law to be necessary for the immediate preservation of the public peace, health and safety, and general welfare, and may be adopted as an emergency regulation in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) (1) Subject to paragraph (2), commencing January 1, 2014, a plan shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(A) He or she or his or her dependent loses minimum essential coverage. For purposes of this paragraph, the following definitions shall apply:

(i) "Minimum essential coverage" has the same meaning as that term is defined in subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

(ii) "Loss of minimum essential coverage" includes, but is not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code. "Loss of minimum essential coverage" also includes loss of that coverage for a reason that is not due to the fault of the individual.

(iii) "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to clause (ii) and Sections 1389.7 and 1389.21.

(B) He or she gains a dependent or becomes a dependent.

(C) He or she is mandated to be covered as a dependent pursuant to a valid state or federal court order.

(D) He or she has been released from incarceration.

(E) His or her health coverage issuer substantially violated a material provision of the health coverage contract.

(F) He or she gains access to new health benefit plans as a result of a permanent move.

(G) He or she was receiving services from a contracting provider under another health benefit plan, as defined in Section 1399.845 or Section 10965 of the Insurance Code, for one of the conditions described in subdivision (c) of Section 1373.96 and that provider is no longer participating in the health benefit plan.

(H) He or she demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the department, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.

(I) He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

(J) With respect to individual health benefit plans offered through the Exchange, in addition to the triggering events listed in this paragraph, any other events listed in Section 155.420(d) of Title 45 of the Code of Federal Regulations.

(2) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to apply for coverage from a health care service plan subject to this section. With respect to individual health benefit plans offered through the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to select a plan offered through the Exchange, unless a longer period is provided in Part 155 (commencing with Section 155.10) of Subchapter B of Subtitle A of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage required pursuant to this section shall be consistent with the dates specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations, as applicable. A dependent who is a registered domestic partner pursuant to Section 297 of the Family Code shall have the same effective date of coverage as a spouse.

(f) With respect to individual health benefit plans offered outside the Exchange, the following provisions shall apply:

(1) After an individual submits a completed application form for a plan contract, the health care service plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 1399.855. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan for which an individual applies during the initial open enrollment period described in subdivision (c), when the subscriber submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014. When

that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, and December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan for which an individual applies during the annual open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15, coverage shall become effective as of the following January 1. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 and December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month. When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(B) Notwithstanding subparagraph (A), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(C) Notwithstanding subparagraph (A), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the

coverage effective date shall be the first day of the month following the date the plan receives the request for special enrollment.

(g) (1) A health care service plan shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability, including conditions arising out of acts of domestic violence.

(H) Disability.

(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.

(2) Notwithstanding Section 1389.1, a health care service plan shall not require an individual applicant or his or her dependent to fill out a health assessment or medical questionnaire prior to enrollment under an individual health benefit plan. A health care service plan shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(h) (1) A health care service plan shall consider as a single risk pool for rating purposes in the individual market the claims experience of all insureds and enrollees in all nongrandfathered individual health benefit plans offered by that health care service plan in this state, whether offered as health care service plan contracts or individual health insurance policies, including those insureds and enrollees who enroll in individual coverage through the Exchange and insureds and enrollees who enroll in individual coverage outside of the Exchange. Student health insurance coverage, as that coverage is defined in Section 147.145(a) of Title 45 of the Code of Federal Regulations, shall not be included in a health care service plan's single risk pool for individual coverage.

(2) Each calendar year, a health care service plan shall establish an index rate for the individual market in the state based on the total combined claims costs for providing essential health benefits,

as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA. The premium rate for all of the health care service plan's health benefit plans in the individual market shall use the applicable index rate, as adjusted for total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA, subject only to the adjustments permitted under paragraph (3).

(3) A health care service plan may vary premium rates for a particular health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 1367.005. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(E) Administrative costs, excluding user fees required by the Exchange.

(i) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

(j) This section shall not apply to an individual health benefit plan that is a grandfathered health plan.

(k) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. ~~300gg-4),~~

300gg-91), subdivisions (a), (b), and (g) shall become inoperative 12 months after that repeal or amendment.

SEC. 5. Section 10127.19 of the Insurance Code is amended to read:

10127.19. *(a) (1)* Commencing March 1, 2013, and at least annually thereafter, every health insurer~~, not including a health insurer offering specialized health insurance policies,~~ shall ~~provide~~ *report* to the department, in a form and manner determined by the department in consultation with the Department of Managed Health Care, the ~~number of covered lives, by product type, as of December 31 of the prior year, that receive health care coverage under a health insurance policy that covers~~ *insurer's enrollment under its health insurance policies, other than specialized health insurance policies, that cover* individuals, small groups, large groups, or administrative services only business lines *as of December 31 of the immediately preceding year*. ~~Health insurers shall include the unduplicated enrollment data in specific product types as determined by the department, including, but not limited to, HMO, point-of-service, PPO, grandfathered, and Medi-Cal managed care.~~ ~~The~~ *This report shall, at a minimum, include the following information:*

(A) The insurer's enrollment in nongrandfathered coverage by product type (HMO, point-of-service, PPO, EPO, Medi-Cal managed care, or other), coverage tier (catastrophic, bronze-HSA, bronze, silver-HSA, silver, gold, or platinum), if applicable, and whether the coverage was purchased through the Exchange or outside the Exchange.

(B) The insurer's enrollment in grandfathered coverage by product type (HMO, point-of-service, PPO, EPO, Medi-Cal managed care, or other).

(2) The department shall publicly report the data provided by each health insurer pursuant to this ~~section~~ *subdivision*, including, but not limited to, posting the data on the department's Internet Web site. ~~The~~

(b) (1) In addition to the report required under subdivision (a), by May 1, 2014, or within 30 days after the end of the initial open enrollment period described in subdivision (c) of Section 10965.3, whichever date is later, a health insurer offering individual health insurance policies shall report to the department, in a form and manner determined by the department in consultation with the

Department of Managed Health Care, the insurer's enrollment under its individual health insurance policies, excluding specialized health insurance policies, as of March 31, 2014, or the date on which the initial open enrollment period described in subdivision (c) of Section 10965.3 ends, whichever date is later. The report shall, at a minimum, include the following information:

(A) The insurer's enrollment in nongrandfathered coverage by product type (HMO, point-of-service, PPO, EPO, Medi-Cal managed care, or other), coverage tier (catastrophic, bronze-HSA, bronze, silver-HSA, silver, gold, or platinum), age and gender, and whether the coverage was purchased through the Exchange or outside the Exchange.

(B) The insurer's enrollment in grandfathered coverage by product type (HMO, point-of-service, PPO, EPO, Medi-Cal managed care, or other) and by age and gender.

(2) (A) By June 1, 2014, or within 60 days after the end of the initial open enrollment period described in subdivision (c) of Section 10965.3, whichever date is later, the department shall report to the fiscal and appropriate policy committees of the Legislature, and post publicly on the department's Internet Web site, the enrollment data submitted by each health insurer pursuant to this subdivision.

(B) The requirement for submitting a report to the fiscal and appropriate policy committees of the Legislature under this paragraph is inoperative four years after the date on which the report required under this paragraph is due, pursuant to Section 10231.5 of the Government Code.

(c) The department shall consult with the Department of Managed Health Care to ensure that the data *collected and* reported *pursuant to this section* is comparable and consistent~~, does not duplicate existing reporting requirements,~~ and utilizes existing reporting formats *to the extent feasible*.

(d) For purposes of this section, the following definitions shall apply:

(1) "Exchange" means the California Health Benefit Exchange established under Section 100500 of the Government Code.

(2) "Grandfathered coverage" means coverage that constitutes a grandfathered health plan under Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education

Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

(3) "Nongrandfathered coverage" means coverage that does not constitute grandfathered coverage.

SEC. 6. Section 10965.3 of the Insurance Code is amended to read:

10965.3. (a) (1) On and after October 1, 2013, a health insurer shall fairly and affirmatively offer, market, and sell all of the insurer's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the insurer provides or arranges for the provision of health care services. A health insurer shall limit enrollment in individual health benefit plans to open enrollment periods, *annual enrollment periods,* and special enrollment periods as provided in subdivisions (c) and (d).

(2) A health insurer shall allow the policyholder of an individual health benefit plan to add a dependent to the policyholder's health benefit plan at the option of the policyholder, consistent with the open enrollment, annual enrollment, and special enrollment period requirements in this section.

(b) An individual health benefit plan issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.

(c) (1) A health insurer shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, and annual enrollment periods for ~~plan~~ *policy* years *beginning* on or after January 1, 2015, from October 15 to December 7, inclusive, of the preceding calendar year, *subject to paragraph (3)*.

(2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar-year individual health plan contracts, a ~~plan~~ *health insurer* shall *also* provide a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

(3) To the extent permitted by PPACA, the Exchange may, by regulation, modify the initial open enrollment period and the annual enrollment period for the policy year beginning on January 1, 2015. A health benefit plan offered in the individual market shall comply with those modifications regardless of whether the plan is offered inside or outside the Exchange. A regulation adopted

pursuant to this paragraph shall be considered by the Office of Administrative Law to be necessary for the immediate preservation of the public peace, health and safety, and general welfare, and may be adopted as an emergency regulation in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) (1) Subject to paragraph (2), commencing January 1, 2014, a health insurer shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(A) He or she or his or her dependent loses minimum essential coverage. For purposes of this paragraph, both of the following definitions shall apply:

(i) "Minimum essential coverage" has the same meaning as that term is defined in subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

(ii) "Loss of minimum essential coverage" includes, but is not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code. "Loss of minimum essential coverage" also includes loss of that coverage for a reason that is not due to the fault of the individual.

(iii) "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to clause (ii) and Sections 10119.2 and 10384.17.

(B) He or she gains a dependent or becomes a dependent.

(C) He or she is mandated to be covered as a dependent pursuant to a valid state or federal court order.

(D) He or she has been released from incarceration.

(E) His or her health coverage issuer substantially violated a material provision of the health coverage contract.

(F) He or she gains access to new health benefit plans as a result of a permanent move.

(G) He or she was receiving services from a contracting provider under another health benefit plan, as defined in Section 10965 or Section 1399.845 of the Health and Safety Code for one of the conditions described in subdivision (a) of Section 10133.56 and that provider is no longer participating in the health benefit plan.

(H) He or she demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the department, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.

(I) He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

(J) With respect to individual health benefit plans offered through the Exchange, in addition to the triggering events listed in this paragraph, any other events listed in Section 155.420(d) of Title 45 of the Code of Federal Regulations.

(2) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to apply for coverage from a health care service plan subject to this section. With respect to individual health benefit plans offered through the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to select a plan offered through the Exchange, unless a longer period is provided in Part 155 (commencing with Section 155.10) of Subchapter B of Subtitle A of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage required pursuant to this section shall be consistent with the dates specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations, as applicable. A dependent who is a registered domestic partner pursuant to Section 297 of the Family Code shall have the same effective date of coverage as a spouse.

(f) With respect to an individual health benefit plan offered outside the Exchange, the following provisions shall apply:

(1) After an individual submits a completed application form for a plan, the insurer shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 10965.9. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan for which an individual applies during the initial open enrollment period described in subdivision (c), when the policyholder submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, and December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan for which an individual applies during the annual open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15, coverage shall become effective as of the following January 1. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 and December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month. When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than

the first day of the second month following delivery or postmark of the payment.

(B) Notwithstanding subparagraph (A), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(C) Notwithstanding subparagraph (A), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the month following the date the insurer receives the request for special enrollment.

(g) (1) A health insurer shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability, including conditions arising out of acts of domestic violence.

(H) Disability.

(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.

(2) Notwithstanding subdivision (c) of Section 10291.5, a health insurer shall not require an individual applicant or his or her dependent to fill out a health assessment or medical questionnaire prior to enrollment under an individual health benefit plan. A health insurer shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(h) (1) A health insurer shall consider as a single risk pool for rating purposes in the individual market the claims experience of all insureds and enrollees in all nongrandfathered individual health benefit plans offered by that insurer in this state, whether offered as health care service plan contracts or individual health insurance policies, including those insureds who enroll in individual coverage through the Exchange and insureds who enroll in individual

coverage outside the Exchange. Student health insurance coverage, as such coverage is defined at Section 147.145(a) of Title 45 of the Code of Federal Regulations, shall not be included in a health insurer's single risk pool for individual coverage.

(2) Each calendar year, a health insurer shall establish an index rate for the individual market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA. The premium rate for all of the health insurer's health benefit plans in the individual market shall use the applicable index rate, as adjusted for total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA, subject only to the adjustments permitted under paragraph (3).

(3) A health insurer may vary premium rates for a particular health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 10112.27. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(E) Administrative costs, excluding any user fees required by the Exchange.

(i) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

(j) This section shall not apply to an individual health benefit plan that is a grandfathered health plan.

(k) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. ~~300gg-4),~~ *300gg-91),* subdivisions (a), (b), and (g) shall become inoperative 12 months after the date of that repeal or amendment and individual health care benefit plans shall thereafter be subject to Sections 10901.2, 10951, and 10953.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SECTION 1. Section 1341.45 of the Health and Safety Code is amended to read:~~

~~1341.45. (a) There is hereby created in the State Treasury the Managed Care Administrative Fines and Penalties Fund.~~

~~(b) The fines and administrative penalties collected pursuant to this chapter, on and after the operative date of this section, shall be deposited into the Managed Care Administrative Fines and Penalties Fund.~~

~~(c) (1) The fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department, beginning September 1, 2009, and annually thereafter, as follows:~~

~~(A) The first one million dollars ($1,000,000) shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 and, notwithstanding Section~~

~~128555, shall not be used to provide funding for the Physician Volunteer Program.~~

~~(B) Any amount over the first one million dollars ($1,000,000), including accrued interest, in the fund shall be transferred to the Major Risk Medical Insurance Fund created pursuant to Section 12739 of the Insurance Code and shall, upon appropriation by the Legislature, be used for the Major Risk Medical Insurance Program for the purposes specified in Section 12739.1 of the Insurance Code.~~

~~(C) Transfers under this paragraph shall cease on the date the Managed Risk Medical Insurance Program becomes inoperative. The Director of Finance shall notify the Joint Legislative Budget Committee at the time the program becomes inoperative.~~

~~(2) Commencing on the date transfers under paragraph (1) cease, and annually thereafter, the fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.~~

~~(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.~~

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